DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

The Honorable Ben Sasse
United States Senate
Washington, D.C. 20510

NOV 18 2015

Dear Senator Sasse:

I am responding to your recent letters concerning the Consumer Operated and Oriented Plan (CO-OP) Program. The Department of Health and Human Services (HHS) takes seriously its oversight of the CO-OP program and we continue to work to respond to your questions.

The CO-OP program, created under the Affordable Care Act (ACA), was designed to offer additional consumer choice and affordability, particularly by encouraging competition through the addition of community-based options. CO-OPs continue to play an important role as they compete to offer cost-competitive plans, build networks, offer benefit designs attractive to consumers and manage medical costs. The climate for CO-OPs has been challenging, and funding has been uncertain, as Congress repeatedly voted to reduce and restrict funds for CO-OPs. The Centers for Medicare & Medicaid Services (CMS) has had more funding requests than it has been able to accommodate and, in some cases, limitations on providing risk corridor payments have hurt some already constrained capital positions. Similar to challenges faced by all health plans at the opening of a new market, CO-OPs had no historical claims experience, lacked information on disease burden or competitive dynamics, and began from a relatively weak position to set premiums and negotiate network contracts.

Implementation of the CO-OP program has been a collaborative effort among CMS, state Departments of Insurance (DOIs), and the new CO-OPs. As you know, states are the primary regulator of health insurance issuers, and market rules and state DOIs oversee the financial stability of issuers and protect consumers in those markets. CMS's role is to monitor CO-OPs for compliance with their loan agreements and program policies. CMS has a dedicated staff with experience in insurance, regulation, financial analysis, actuarial science, and operating management. The implementation team was supplemented by outside experts from Deloitte.

All CO-OPs are subject to a standardized, ongoing program of oversight activities that include monthly, biweekly, or weekly calls to monitor a variety of key activities and goals; periodic on-site visits; performance and financial auditing; monthly, quarterly, semi-annual, and annual reporting obligations; and a host of additional measures employed as needed on a case-specific basis. CMS continues to monitor each CO-OP's performance and take steps to assist each CO-OP and protect their enrollees. However, CO-OPs are still start-up entities competing against large and well-established entities and thus, as with any start-up company, may not succeed in becoming viable and sustainable. CMS reviews have resulted in the rejection of initial application funding to 123 entities and the rejection of 7 conversion loan requests. CMS takes its role of protecting taxpayer funds seriously. Funds that remain undisbursed will be used to

support reasonable plans by CO-OPs to continue to compete and serve their markets or to protect the ability of CO-OPs to meet claims obligations.

I. CoOportunity

Health insurance issuers participating in the Marketplaces in the initial years have faced uncertainty in the pricing of their plans. Like most issuers in new markets, CoOportunity had to set premium rates without knowledge of the claims experience of its membership or their need for care. While larger, established health plans had the same limitations, they generally had significantly larger capital reserves to help mitigate risk. Adding to this uncertainty was the enrollment of a substantial portion of Marketplace consumers after the start of the calendar year. Although the first open enrollment period began on October 1, 2013, records provided by the CO-OP indicate that about half of CoOportunity's members enrolled in the final month of the open enrollment period, which ended March 31, 2014. With coverage for a significant portion of its membership not beginning until April 1, 2014, CoOportunity had limited claims experience on which to base important financial decisions.

As noted above, because 2014 was the first year of operations, and consumers continued to enroll in coverage through the first quarter of 2014, data from CoOportunity regarding its performance was limited. Regardless, CMS worked closely with CoOportunity's leadership and the state DOIs to monitor progress throughout 2014. Such oversight included routine teleconferences, regular reporting, and review of qualitative and quantitative data available at the time.

CoOportunity submitted an application for $32.7 million in solvency loan funding on June 18, 2014 in response to a CMS announcement of additional CO-OP loan funding on April 30, 2014. CMS treated each request for funding in 2014 as an independent request. As part of this process, CMS reviewed applications, assessed updated business plans, conducted feasibility studies, and also assessed programmatic and regulatory compliance, actuarial soundness, and pro forma financial statements. The applications included actuarially-certified analyses and financial projections, which incorporated data regarding the current, and projected, level of enrollment. CMS also considered additional factors such as the reasonableness and viability of the business plan, contingency plans, market impact, and CMS's evaluation of the CO-OP experience and performance to date.

Similar to our review of initial loan applications, CMS retained an outside consultant to convene an external review panel of subject matter experts to review all applications for additional solvency loan funding. As stated above, because CoOportunity was in its first few months of operations, and because a significant number of consumers began their coverage well into 2014, the available data showing CoOportunity's claims experience and performance was limited. After receiving a recommendation from an independent outside consultant, CMS awarded an additional solvency loan of $32.7 million to CoOportunity. Loan awards for this round of funding were announced on September 26, 2014, after the loan agreements had been signed by the CO-OPs.

On August 22, 2014, CMS announced the availability of a final round of CO-OP loan funding. On September 22, 2014, CoOportunity submitted a request for $55 million in additional solvency loan funding. When CoOportunity applied for this round of additional solvency funding, it was

able to provide another several months of updated claims and financial data that were not available when CMS reviewed its request in response to the April 30, 2014, funding announcement. Using the same rigorous review of the applications described above, it became clear to CMS, as well as to the Nebraska and Iowa DOIs, that the financial trends and projections for CoOportunity had rapidly deteriorated. This data showed that higher than expected enrollment, along with much higher rates of utilization than projected, created serious liquidity and financial challenges for CoOportunity. As a result, on December 13, 2014, CMS informed CoOportunity that the CO-OP would not receive additional solvency funding. CMS also denied additional solvency loan funding requests for CO-OPs in South Carolina, Colorado, and New York because they did not meet the evaluation criteria and because of the limited availability of funds.

During this time, the state DOIs were simultaneously reviewing the updated enrollment, claims, financial, and other data as it became available. Based on this data, and the determination that the financial situation of CoOportunity was deteriorating rapidly, the Iowa DOI placed CoOportunity in rehabilitation on December 23, 2014. On January 23, 2015 the state determined that rehabilitation was not possible and announced that it would seek a liquidation order. At that time, CMS worked quickly to protect consumers enrolled in CoOportunity to maintain their access to affordable coverage. Enrollees in CoOportunity plans were offered a 60-day special enrollment period to select a new qualified health plan (QHP) and continue receiving financial assistance. CMS actively engaged in numerous outreach activities to reach all CoOportunity members and work with them to ensure they came back to the Marketplace to shop for, and enroll in, new affordable coverage for the remainder of 2015.

You also asked about the rate review process and CMS's role in that process. While rate review has historically been conducted by state regulators, the ACA introduced a uniform framework to review unreasonable rate increases for health insurance coverage and established a grant program to assist states with enhancing their respective rate review programs. Nebraska was able to improve its rate review process, develop and upgrade data reporting technology and increase transparency and accountability of health insurance rates in the state through two ACA rate review grant awards to the state, totaling $3,000,000. Both Nebraska and Iowa have been deemed to have effective rate review programs, so the states, not CMS, are responsible for conducting the annual rate review of the insurance plans offered by issuers in their respective states, including CoOportunity. CMS did receive rate information as part of our analysis of subsequent requests for loan funding, but because Nebraska and Iowa had responsibility for reviewing rates, CMS did not review the rates for purposes of determining reasonableness.

Finally, in regards to CoOportunity, you asked about CMS's efforts to recoup funds. CoOportunity is in the process of regulatory liquidation pursuant to a liquidation order issued under the Iowa Insurers Supervision, Rehabilitation, and Liquidation Act, in the matter captioned *Nick Gerhart, Commissioner of Insurance v. CoOportunity Health*, Case No. EQCVE077579, before the Iowa District Court for Polk County. CMS anticipates that the loans will be repaid to the extent funds remain available for the class of claims applicable to CMS's claims under the liquidation order or other means of recovery that may be available to CMS. The liquidator submits regular filings in the liquidation proceeding.

In the liquidation proceeding, CMS, as a lender, stands as a creditor that will present a claim in accordance with the order of liquidation. In liquidation under Iowa law, however, the liquidator

is vested with title to all property and all the powers of the company in liquidation and has sole responsibility for overseeing the administration of policies in force. Like all consumers under the ACA, CoOportunity members were protected against the loss of coverage as a result of the various rights and provisions in the ACA such as special enrollment periods through the Marketplace and the guaranteed issue provisions. Based on the most recent report of the liquidator, CMS anticipates that at most 368 members were affected by the termination of the remaining plans as of August 31, 2015.

II. Louisiana Health Cooperative

CMS became aware of the regulatory issues affecting Louisiana Health Cooperative (LHC) in December 2014 when the state DOI required LHC to take immediate steps to address identified systemic failures and ensure their compliance with all regulatory requirements. As stated previously, CMS's role is to monitor CO-OP compliance with the loan agreements and our program policies, which includes compliance with all applicable state requirements. As a result of the state action, CMS required LHC to develop and submit a plan to address the concerns raised by the DOI in January 2015.

In April 2015, CMS notified LHC that based on submission of its quarterly reports, the March 2015 plans to remediate their regulatory and performance issues failed to sufficiently address the problems that CMS identified. Specifically, the reply did not provide complete or adequate explanations of LHC's plans to resolve regulatory concerns identified by the DOI, and also failed to fully address concerns CMS had identified in relation to requirements under the CMS loan agreement, such as solvency level, sustainable enrollment levels, network sufficiency, and operational concerns. In April 2015, and again in June, CMS required LHC to expand and improve its plan to address both the regulatory and financial issues that had been identified. However, as you know, LHC was unable to remedy the identified issues and the CO-OP Board voted to end operations at the end of 2015. CMS, along with the DOI, are working closely to ensure an orderly wind down process that first and foremost protects LHC's current enrollees.

In further response to your letter, please find enclosed a disc containing the quarterly financial filings of the 12 CO-OPs you requested. These are also accessible through the state Departments of Insurance.

I appreciate your continued interest in this important topic.

Sincerely,

Jim R. Esquea

Jim R. Esquea
Assistant Secretary
for Legislation